

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012951

FILED MAY 11 1959

Registration District No. 128 Primary Registration District No. 2000 STATE FILE NUMBER Registrar's No. 4376

300
-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		c. CITY OR TOWN Aurora	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Ozark Osteopathic		d. STREET ADDRESS Box # 5	
3. NAME OF DECEASED (Type or print) First Middle Last Laurel Marie Hill		4. DATE OF DEATH Month Day Year April 30, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 63
11. BIRTHPLACE (City and state or country) Wilson, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME William A. Haffa		13b. MOTHER'S MAIDEN NAME Sara F. Menzies	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT W. A. Hill, 2101 W. Chestnut, Springfield, Mo.		14. NAME OF HUSBAND OR WIFE Box 5 Arthur Hill, Aurora, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Circulatory failure Congestive heart failure Hypothyroidism DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Immediate 4 days Unknown.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 253X	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from April 12, 1959 , to April 30, 1959 and last saw her alive on April 30, 1959 Death occurred at 4:22 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Andrew Martinick, D.O.		22b. ADDRESS 700 E. Sunshine, Springfield, Mo.	
22c. DATE SIGNED 4/30/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2 MAY 59	23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK	23d. LOCATION (City, town, or county) (State) AURORA MO
24. FUNERAL DIRECTOR ARNOLD FUNERAL HOME		25. DISEASE RECORD BY LOCAL AGENCY 30 APR 59	
ADDRESS AURORA, MO		26. REGISTRAR'S SIGNATURE Effie E. Melton	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 466

P. O. Address Aurora, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.